STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155480	A. BUILDING _____ B. WING _____	R-C 07/19/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKVILLE HEALTHCARE CENTER	11049 SR 101 BROOKVILLE, IN 47012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00109321 completed on 6/28/12. This visit was in conjunction to the Investigation of Complaint number IN00111587 and IN00112161. Complaint IN00109321 corrected. Survey Dates: July 17, 18 & 19, 2012 Facility number: 000550 Provider number: 155480 AIM number: 100286110 Survey team: Leslie Parrett, RN Census bed type: SNF/NF: 75 Total: 75 Census payor type: Medicare: 9 Medicaid: 53 Other: 13 Total: 75 Sample: 3 Brookville Healthcare Center was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2 in regard to the PSR to the Investigation of Complaint IN00109321. Quality review completed 7/26/12 Cathy Emswiller RN	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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